Members Health
FUND ALLIANCE

Submission to the Senate Community Affairs Legislation Committee Inquiry into the Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026

21 August 2026

Horsley, NSW

My wife and I are both age pensioners and if this happens we be forced to cancel our Health Insurance and use the public system.

Kingston, Tasmania

My sole income is the Aged Pension, any increase to my health care costs other than the annual increase will cause me to have to consider whether I continue with my health cover. My age is 86 and the ability to have access to health care when I need it is of paramount importance to me.

Bayswater, Western Australia

We are a couple with only income being the gov age pension who have under $50k savings & no superannuation who rely on private health insurance to manage cancer treatment are now going to have reevaluate if we can afford private health insurance and start relying on the public health system, which will not give us the quality of care we are now getting, adding to the governments health care costs. Why punish the people who are doing it hard already.

Encounter Bay, South Australia

After having top health cover all my life, and rarely using it, I now have to consider cancelling it and rely on Public Hospitals. I expect many will do the same so waiting lists will be longer. I am retired and rely on the Age Pension and a modest Annuity to cover the increasing bills coming in. Something has to give so Health Insurance is the one I may have to lose if the cost goes up.

Wanniassa, ACT

Higher health insurance costs would lead us to rely solely on the public system as health insurance would be unaffordable.

Winnellie, Northern Territory

The government force you into this under threat of increased cost to you if you don't comply, Then force you out of it with cost imposts and put increased strain on the public system.

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21 August 2026

Committee Secretary
Community Affairs Legislation Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

E: community.affairs.sen@aph.gov.au

Re: Senate Community Affairs Legislation Committee Inquiry into the Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026

Members Health Fund Alliance (Members Health) welcomes the opportunity to provide a submission to the Senate Community Affairs Legislation Committee inquiry into the *Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026*.

Members Health strongly opposes the Bill.

We acknowledge the Government's objectives of strengthening aged care, improving the targeting of public expenditure and simplifying the rebate structure. However, we are concerned that the assumptions underpinning the Bill do not adequately account for the role older Australians play in Australia's mixed public-private healthcare system, nor the likely behavioural responses to increased premiums and the broader consequences for healthcare affordability, hospital capacity, aged care and regional health services.

Members Health's concern is not only that the Bill will increase out-of-pocket costs for older Australians. It is that the Bill may shift healthcare demand from privately funded settings into already stretched public hospitals, worsening waiting times and access to care for all Australians, including people who already rely entirely on the public system.

Members Health would welcome the opportunity to provide further evidence to the Committee.

Yours sincerely

MATTHEW KOCE
Chief Executive Officer
Members Health Fund Alliance

Members Health
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Executive Summary

Members Health is the national peak body representing around 20 not-for-profit, member-owned, regional and community-based private health insurers that collectively serve more than 5.4 million Australians. Our funds exist solely to serve their members, not shareholders, and play an important role in supporting the sustainability, accessibility and affordability of Australia's healthcare system.

Members Health opposes the proposed removal of the age-based uplift to the Private Health Insurance (PHI) Rebate for Australians aged 65 and over.

The Bill would directly affect approximately 3.05 million privately insured Australians aged 65 and over, representing around 92 per cent of all insured Australians in that age cohort. Around 2.13 million of those affected have incomes of $55,000 or less, while more than 80 per cent are currently receiving the base-tier rebate. The practical effect of the proposal is therefore concentrated among lower and middle-income retirees, rather than high-income Australians.

Members Health is concerned that the Bill will have two connected consequences. First, it will impose a direct affordability shock on older Australians, many of whom are on fixed or modest incomes. Second, it risks shifting healthcare demand from privately funded settings into already stretched public hospitals, with consequences for all Australians who rely on timely access to care.

The Bill does not reduce older Australians' underlying need for healthcare. If people downgrade or cancel private health insurance, care is delayed or shifted to the public system. Previous Government-commissioned actuarial modelling estimated that removing the higher rebate could reduce Commonwealth rebate expenditure by around $482 million while shifting between $418 million and $547 million in additional hospital costs onto the public system.[1] Although the precise estimates are sensitive to assumptions about lapsing and downgrading, the direction of effect is clear: a substantial proportion of the Commonwealth saving may be offset by increased public hospital expenditure.

Members Health is particularly concerned by the assumption that older Australians will simply absorb the additional cost. More than 4,100 responses to Members Health's national rebate campaign indicate otherwise: 87 per cent referenced affordability or financial strain, while 45 per cent indicated they would consider downgrading or cancelling cover. Downgrading is a particular risk because a person may remain counted as insured while losing cover for services such as cataracts, joint replacements and mental health treatment, shifting care into the public system or contributing to delayed treatment and increased aged care demand.

Older Australians are not a marginal cohort within the private hospital system. In 2023-24, people aged 65 and over accounted for 48.8 per cent of private hospital admissions. A behavioural response affecting this cohort therefore has implications for almost half of private hospital activity and for the public hospitals that may be required to absorb displaced demand.

Australia's healthcare system is built on a deliberate partnership between the public and private sectors. Private hospitals undertake the majority of elective surgery and provide critical additional capacity that supports public hospitals and expands consumer choice. The Private Health Insurance Rebate is one of the core policy settings supporting participation in

[1] https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/supporting_documents/Finity%20Consulting%20MLS%20and%20PHI%20Rebate%20Final%20Report.pdf

this mixed system alongside Community Rating, Lifetime Health Cover and the Medicare Levy Surcharge. Changes to the rebate should therefore be assessed not merely as a budget measure, but as a reform with broader implications for health system sustainability.

The consequences are likely to be particularly significant in regional and rural Australia, where populations are older, health outcomes are generally poorer, workforce shortages are more acute, and many private hospitals operate on narrow or negative margins. Even relatively small reductions in private participation among older Australians may have disproportionate consequences for local access to care and the viability of regional health services. Tasmania provides a practical example of these risks, as outlined later in this submission.

These concerns are shared across the health sector, including by hospitals, doctors, consumer advocates, medical technology suppliers, seniors groups and private health insurers.

Ultimately, Members Health believes the central question before the Committee is not simply whether the Commonwealth can reduce expenditure on the Private Health Insurance Rebate. Rather, it is whether the assumptions underpinning the Bill adequately account for the real-world responses of older Australians and the broader consequences for Australia's mixed public-private healthcare system.

For these reasons, Members Health recommends that the Committee recommend that the Bill not proceed.

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About Members Health Fund Alliance

Members Health is the national peak body representing around 20 not-for-profit, member-owned, regional and community-based private health insurers serving more than 5.4 million Australians. Our members exist to serve policyholders rather than shareholders and focus on competitive premiums, strong benefits, service and community health.

Members Health funds operate nationally, including in regional communities, and support access to dental, optical, physiotherapy, hospital and other healthcare services. Further information about Members Health is provided in Appendix A.

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Members Health
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Recommendations

Members Health makes the following recommendations to the Inquiry:

1) **The Committee recommend that the Bill not proceed.**

In support of this recommendation, Members Health notes that:

1) No independent analysis or community consultation has been undertaken to justify implementation of the Bill, and further work would be required before any commencement.

2) The Government has not published sufficient modelling assumptions relating to lapsing, downgrading, public hospital utilisation, private hospital impacts, regional impacts, aged care impacts, State and Territory budget impacts, or impacts on pensioners and lower-income retirees.

3) No specific modelling has been undertaken on Gold-to-Silver downgrade behaviour among Australians aged 65 and over.

4) No post-implementation monitoring framework has been established to track participation rates, downgrading rates, public hospital demand, private hospital activity, aged care impacts or regional impacts, nor has the Government identified what corrective action would be triggered if actual impacts exceed its forecasts.

5) The Government has not published a sufficient whole-of-health system impact assessment examining consequences for public hospital waiting times, elective surgery access, aged care demand, carers, private hospital viability or regional health services.

6) The Committee cannot be satisfied that proposed Commonwealth savings will not be offset by increased costs, longer waiting times and reduced access elsewhere in the health system, because no such analysis has been sufficiently undertaken.

2) **The Committee recommend that the Federal Government restore the policy intent of private health insurance incentives including:**
   - **end indexation of the private health rebate, and;**
   - **move toward restoring the base rebate back to 30 percent for lower-income Australians, to directly improve affordability and support participation.**

In support of this recommendation, Members Health notes that:

1. Broadening participation will strengthen community rating, particularly among younger and healthier Australians. Unless this is achieved, the risk pool will continue to age, increasing claims costs and premium growth over time. The result will be that health insurance may become available only to the wealthy.

2. For this reason, Members Health considers that reform should focus on strengthening participation incentives for lower income younger and working-age Australians rather than reducing support for cohorts already strongly engaged in the private health system.

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1. Australia's Mixed Public-Private Healthcare System and the role of the Private Health Insurance Rebate

Australia's healthcare system is built on a deliberate partnership between the public and private sectors. Medicare provides universal access to healthcare, while private health insurance and private hospitals provide additional capacity, choice and access that support the overall system.

Members Health strongly supports Australia's uniquely mixed public and private health model. It is one of the reasons Australia achieves strong health outcomes by international standards. Private health insurance and private hospitals are not peripheral to Australia's healthcare system. They undertake the majority of elective surgery and provide important capacity that would otherwise need to be absorbed by the public health system.

Australia's mixed public-private healthcare system performs strongly by international standards. Medicare provides universal access, while private health insurance and private hospitals add capacity, choice and timely access to care. Private hospitals undertake the majority of elective surgery and provide capacity that would otherwise need to be absorbed by the public system.

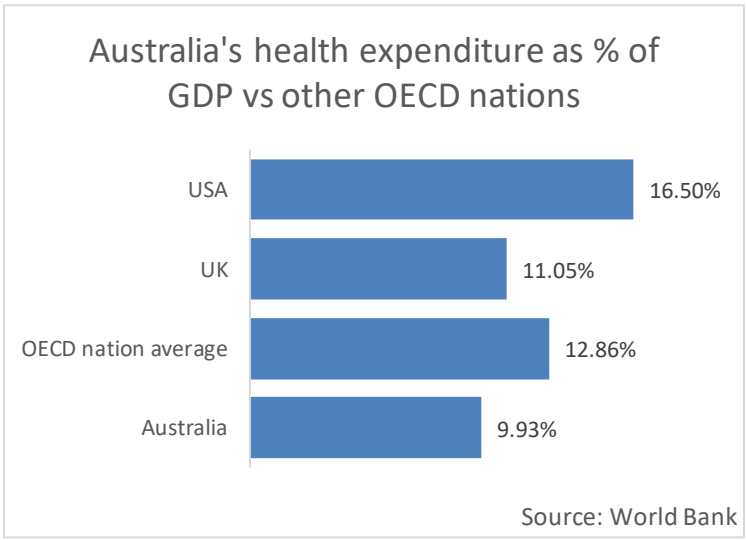
Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	SWE	SWIZ	UK	US
OVERALL RANKING	**1**	**7**	**5**	**9**	**2**	**4**	**6**	**8**	**3**	**10**
Access to Care	9	7	6	3	1	5	4	8	2	10
Care Process	5	4	7	9	3	1	10	6	8	2
Administrative Efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	–	4	5	9
Health Outcomes	1	4	5	9	7	3	6	2	8	10

Note: SWE overall ranking calculation does not include Equity domain. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

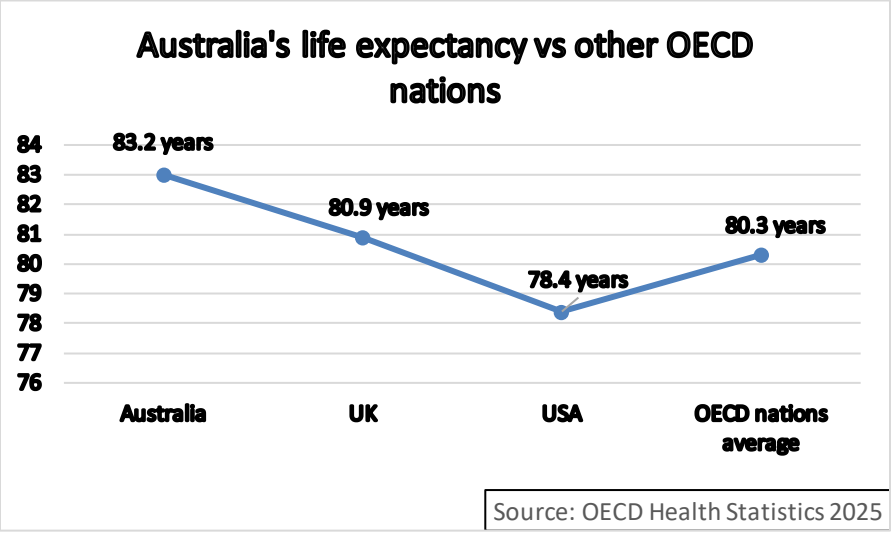
[2]



Australia also maintains health expenditure below the OECD average as a share of GDP.

Australia's health expenditure is approximately 9.93 per cent of GDP, below the OECD average of 12.86 per cent, and below comparable figures for the United Kingdom and United States[3].

[2] Commonwealth Fund Mirror, Mirror 2024
[3] Current health expenditure (% of GDP) - Australia | Data

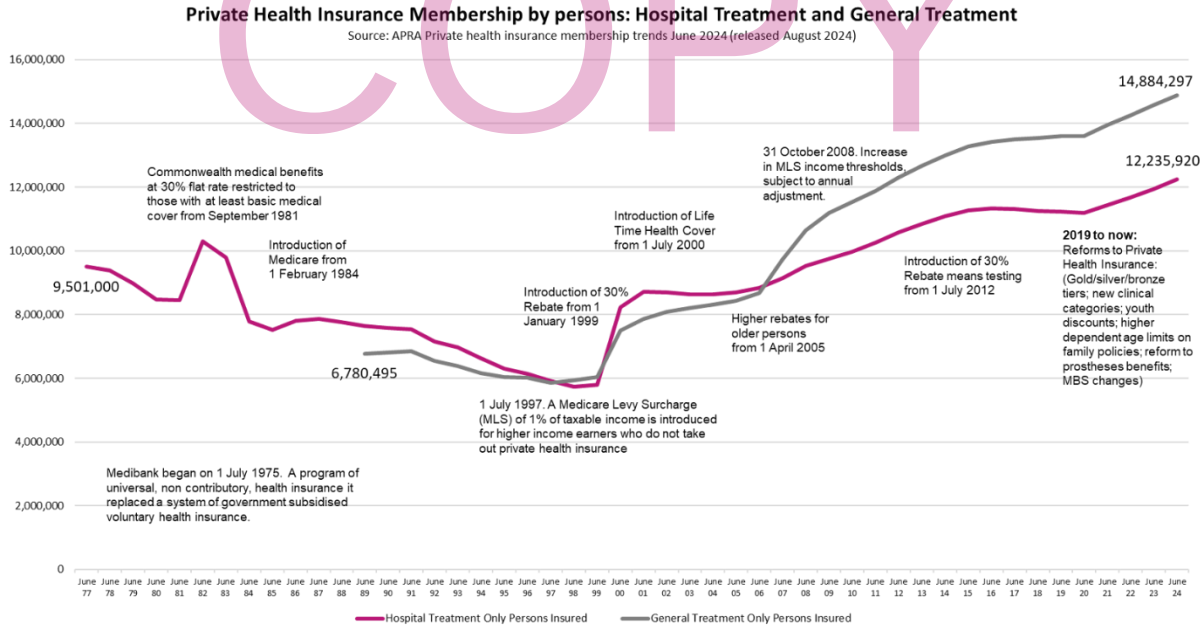


[4]

Australia's life expectancy at birth is 83.2 years, approximately three years higher than the OECD average of 80.3 years, and ahead of the United Kingdom at 80.9 years and the United States at 78.4 years.

This performance reflects the value of a system that combines universal public access with private sector capacity. Policy settings that weaken one part of this system should therefore be assessed carefully for whole-of-system impacts.

The Private Health Insurance Rebate operates alongside Lifetime Health Cover and the Medicare Levy Surcharge as part of the policy architecture supporting private health insurance participation. These measures helped reverse declining participation in the late 1990s and have supported the stability of the mixed system since.



The PHI Rebate should be understood as a health system investment, not merely as a Commonwealth expense.

In the 12 months to 30 September 2025, insurers paid out increased benefits of more than $26.7 billion in health, medical and extras benefits[5], supporting privately funded care that would otherwise place far greater pressure on public hospitals and government budgets. This represents an excellent return on investment for Government, which invests a total of around $7.9 billion annually.

[4] OECD Health Statistics 2026

[5] Media Release, Minister for Health Hon Mark Butler MP, 17 February 2026

Weakening the affordability of private health insurance for older Australians, risks reducing privately funded activity and shifting much greater demand back into the overstretched public system. Analysis by Finity Consulting and Avant Mutual/ DeltaPearl Partners indicates that the rebate more than pays its way by supporting private health insurance participation and reducing costs that would otherwise fall on the public system[6].

The rebate has already been progressively eroded from its original base rate of 30 per cent through means testing, indexation changes resulting in declining rebate percentages. The Bill would accelerate that trajectory by dramatically removing the age-based uplift for Australians aged 65 and over. In practical terms, this would further reduce the rebate's affordability function for the means tested cohort most likely to need hospital care and most important to sustaining private hospital activity and viability.

The rebate was introduced as part of a broader participation framework to support long term private health insurance participation and reduce pressure on the public system. Weakening that framework for older Australians risks producing the opposite of the Government's stated objective by shifting costs and demand back into public hospitals.

The Bill should therefore be assessed as a health system reform, not solely as a budget measure. The question is whether reducing support for older Australians will weaken participation, increase public hospital demand and undermine a system that presently supports strong outcomes, consumer choice and shared responsibility.

2. Community Rating and Why It Matters

Community rating is one of the foundational principles of Australia's private health insurance system. It means that Australians pay the same premium for the same product regardless of age, gender, health status or claims history.

This principle is central to fairness and access. It ensures older Australians and people with higher healthcare needs can access private health insurance at the same price as younger and healthier people.

However, community rating depends on a broad and balanced risk pool. Private health insurance works best when younger, healthier people participate and older, higher-claiming people remain insured. If affordability pressures cause people to leave or downgrade their cover, the risk pool can become less balanced, and premiums can come under further pressure.

This is why Members Health recommends restoring the private health rebate for lower-income Australians to 30 percent. This will directly improve affordability and support greater participation.

This issue is especially important in relation to comprehensive Gold cover. Gold cover provides the most comprehensive hospital coverage and is the product tier most exposed to risk concentration because it is also the tier more likely to be retained by people with higher healthcare needs.

Comprehensive Gold hospital cover has faced significant pressure since the introduction of standardised product tiers in 2019. The proportion of Australians holding Gold hospital cover has fallen by over 10 percent, from 40.1 per cent in June 2020 to 29.3 per cent in December 2025. Members Health is concerned that the proposed rebate changes may

[6] https://www.finity.com.au/news-and-insights/Optimising-private-health-insurance-findings-and-possibilities

accelerate this trend by making comprehensive cover less affordable for older Australians, who are among the people most likely to need high-acuity hospital services.

If older Australians downgrade from Gold cover because of the proposed rebate change, the consequences could include:

- fewer people holding comprehensive cover;
- reduced private coverage for high-acuity care;
- increased public hospital demand;
- reduced private hospital activity;
- further pressure on the sustainability of Gold products; and
- weakening of the community-rated risk pool.

Members Health submits that the Committee should consider this reform in the context of broader private health system sustainability, not simply as an isolated rebate adjustment.

Under community rating, members who claim relatively little still contribute to the stability of the overall risk pool. If the policy leads lower-claiming members to leave or downgrade, the remaining insured pool may become more concentrated with higher expected claims costs. Over time, this can contribute to upward premium pressure for remaining policyholders and further weaken affordability – pushing people out of private health and damaging Australia's healthcare outcomes.

For this reason, the Committee should consider not only the effect of the Bill on those who leave or downgrade cover, but also the potential consequences for remaining policyholders.

The Bill should therefore be considered not only as a change to rebate levels, but as a policy change with potential implications for community rating, risk pooling, Gold cover sustainability and private hospital activity.

3. The Bill and Members Health's Position

The Bill proposes to remove the higher Private Health Insurance Rebate currently available to Australians aged 65 and over who pass a means test.

Under current arrangements, the rebate increases at age 65 and again at age 70, subject to income thresholds. The Bill would remove these age-based rebate uplifts from 1 April 2027, meaning Australians aged 65 and over would receive the same rebate as those aged under 65, subject to the existing income tiers. For Australians aged 70 and over that would mean slashing the rebate from 32.158% to 24.118%.

In his Second Reading Speech, the Minister described the Bill as a measure to improve intergenerational equity, simplify the rebate and better target public expenditure. The Minister also stated that savings from the measure would be directed towards aged care.

Members Health acknowledges the Government's objectives of strengthening aged care, ensuring public expenditure is well targeted and maintaining an equitable healthcare system. These are legitimate policy objectives.

However, Members Health does not support the proposed mechanism. The Bill would remove support from a cohort that is:

- more likely to be living on a pension, or modest fixed income;

- more likely to require hospital care;
- more likely to hold comprehensive cover;
- important to private hospital activity and viability; and
- central to the sustainability and effectiveness of Australia's mixed public-private healthcare system.

Members Health is concerned that the assumptions underpinning the Bill may underestimate:

- behavioural responses, including downgrading and cancellation;
- impacts on lower-income older Australians;
- consequences for public hospital demand;
- impacts on private hospital viability;
- regional and rural health service consequences;
- impacts on aged care and carers; and
- broader effects on community rating and system healthcare sustainability.

Members Health is especially concerned that the Bill may worsen access to public hospital services for Australians who never held private health insurance. If older Australians shift into the public system, the impact will be felt across waiting lists and hospital capacity more broadly, including by lower-income people, regional communities and patients with chronic illness already waiting for care.

For these reasons, Members Health submits that the Bill should not proceed.

4. Equity, targeting and policy objectives

The Government has framed the Bill as an equity measure, arguing that two households on the same income should receive the same rebate regardless of age.

Members Health accepts that equity is an important policy objective. However, health policy should be assessed not only by whether individuals receive identical support, but by whether policy settings deliver the intended health system outcomes.

Older Australians are not similarly situated to younger Australians when it comes to health need. They are more likely to require hospital care, more likely to need high-acuity treatment and more likely to use services such as joint replacement, cataract surgery, cardiac care and rehabilitation.

A 72-year-old retiree and a 35-year-old worker on the same income may look similar for tax purposes, but they are not similarly placed in respect of healthcare need, capacity to earn additional income or likely reliance on hospital services.

Members Health therefore submits that equal treatment does not always produce equitable outcomes. We also note that as younger people age, they will qualify for a higher rebate.

The impacts may also be unevenly distributed by gender. Women generally retire with lower superannuation balances and are more likely to rely on the Age Pension later in life. As a result, older women may have less financial capacity to absorb a sudden increase in private health insurance costs. The distributional impacts of the Bill, including its effects on older women, should have been examined before the legislation was introduced.

A policy that removes support from older Australians at the point their healthcare needs increase may appear equal in a narrow sense but may produce inequitable outcomes in practice by reducing affordability for those least able to adjust and increasing pressure on the

broader health system. We also note that if people drop cover, they will be unlikely to re-enter in the future due to the impact of Lifetime Health Cover Loading, which rightly encourages long term, rather than 'hit and run' health fund membership.

The Private Health Insurance Rebate is not a general transfer payment. It is a means tested health system participation mechanism. Its purpose should be assessed by reference to its impact on private health insurance participation, public hospital demand, private hospital sustainability, access to timely care and Australia's leading performance when benchmarked internationally. Longer public waiting lists do not fall equally across the population. They disproportionately affect people without the means to self-fund care, people in regional areas with fewer alternatives, people with chronic illness and people already waiting for clinically necessary treatment.

5. Impact on lower-income older Australians

Members Health analysis indicates that the Bill would affect approximately 3.05 million insured Australians aged 65 and over. Of these, approximately 2.13 million have incomes of $55,000 or less. Around 92.4 per cent of insured Australians aged 65 and over would be impacted by the proposed rebate reduction.

The impact is heavily concentrated among lower and modest income retirees. Around 70 per cent of affected older Australians are in the base income tier. Some industry modelling[7] has estimated that 400,000 full and part age pensioners hold private health insurance and will be exposed to the proposed rebate reduction. This reinforces that the Bill is not principally a measure affecting affluent retirees. It will affect a substantial number of older Australians living on pensions and modest fixed incomes.

Income tier	65 - 69	70+	Total 65+
	Insured persons		
Base	688,502	1,857,387	2,545,889
1	69,722	109,258	178,980
2	34,861	65,555	100,416
3	78,437	152,961	231,398
Total insured persons	871,521	2,185,161	3,056,682
Insured persons with $55k or below	539,293	1,588,691	2,127,984
$55k or below as % of insured	61.9%	72.7%	69.6%
Base	79.0%	85.0%	83.3%
1	8.0%	5.0%	5.9%
2	4.0%	3.0%	3.3%
3	9.0%	7.0%	7.6%
Total	100.0%	100.0%	100.0%
Total impacted %	91.0%	93.0%	92.4%

Members Health analysis indicates that the impact of the Bill is concentrated among lower and modest income older Australians. The majority of insured Australians aged 65 and over affected by the proposal are in the base income tier, and approximately 70 per cent have incomes of $55,000 or less.

The Government's framing of the policy as a move from age-based to income-based support does not fully reflect the practical impact of the change. Many of those affected are already in

[7] Private Healthcare Australia

the lowest income tier and will still face a significant reduction in support.

Consumer feedback received through Members Health's national rebate campaign further supports this concern. Of more than 4,038 responses received at the time of writing, 87 per cent referenced financial strain.

Evidence from one of the Members Health funds with a significant membership presence in Tasmania also demonstrates that affordability concerns are particularly acute among lower-income retirees. Among more than 3,600 members aged over 65 surveyed by St Lukes Health, 77 per cent earned less than $55,000 per year and 32 per cent earned less than $30,000 per year.

This evidence demonstrates that the proposal will have its most significant practical effect on older Australians who have limited capacity to absorb additional costs. This is a key reason Members Health recommends that the Bill not proceed.

6. Affordability impacts

The proposed changes would materially increase the effective cost of private health insurance for older Australians.

Members Health analysis indicates that the average impact would be approximately a 9 per cent increase in out-of-pocket premium costs, or around $280 per year, before accounting for ordinary annual premium increases.

For a typical standalone Gold hospital policy, the estimated impact is approximately:

- $160 per year for an insured person aged 65 to 69 in the base tier; and
- $320 to $330 per year for an insured person aged 70 and over in the base tier.

For older Australians with Gold hospital cover and extras, the impact may be higher. State-based analysis indicates that some older Australians may face increases of up to approximately $400 per person on top of ordinary annual premium increases. For couples or households with more than one affected policyholder, the combined impact may be materially higher.

The rebate reduction would take effect alongside the ordinary annual premium adjustment. Many older Australians would therefore experience a substantial one-off increase equivalent to several years of normal premium growth, despite often having limited capacity to increase their income. For retirees on fixed incomes, every additional cost requires an offset elsewhere in the household budget. In the feedback received by Members Health, many respondents identified that higher private health insurance costs would force difficult choices between insurance, food, utilities, transport, medication, home maintenance and other essential expenses. These choices could result in very poor health outcomes and earlier aged care admission, even if health insurance is maintained.

Health insurers themselves are also under significant cost pressures. The Australian Prudential Regulation Authority notes in its Corporate Plan that *"private health insurers face ongoing pressure from an ageing population, rising health claims costs and affordability challenges for policyholders."*[8]

The affordability impact therefore has both household and health system dimensions. If older Australians respond by cancelling or downgrading cover, the pressure is not removed from the health system. It is transferred to public hospitals, aged care services, carers and families.

[8] APRA Corporate Plan 2026/2027, p.8.

Typical Gold premium $			65 - 69				70+			
			Rebate changes		Impact on effective premium		Rebate changes		Impact on effective premium	
	Standalone	With extras cover	Standalone	With extras cover	Standalone	With extras cover	Standalone	With extras cover	Standalone	With extras cover
ACT	4,060	5,040	162	202	5.6%	5.6%	329	408	11.9%	11.9%
NSW	4,060	5,040	162	202	5.6%	5.6%	329	408	11.9%	11.9%
VIC	4,341	5,176	174	207	5.6%	5.6%	352	419	11.9%	11.9%
QLD	4,300	5,271	172	211	5.6%	5.6%	348	427	11.9%	11.9%
WA	3,448	4,488	138	180	5.6%	5.6%	279	364	11.9%	11.9%
SA	3,836	4,914	153	197	5.6%	5.6%	311	398	11.9%	11.9%
TAS	3,949	4,633	158	185	5.6%	5.6%	320	375	11.9%	11.9%
NT	2,440	3,357	98	134	5.6%	5.6%	198	272	11.9%	11.9%
Industry	**4,072**	**5,022**	**163**	**201**	**5.6%**	**5.6%**	**330**	**407**	**11.9%**	**11.9%**

For older Australians on comprehensive Gold cover, the proposed change represents a material out-of-pocket increase on top of ordinary annual premium increases.

7. Long-term policyholders and reasonable expectations

Many older Australians affected by the Bill have held private health insurance for decades. They have maintained cover through their working lives, into retirement and often through periods when they made limited claims.

In doing so, they have responded to longstanding policy settings that encouraged Australians to take out and retain private health insurance. These settings include the Private Health Insurance Rebate, Lifetime Health Cover and the Medicare Levy Surcharge.

Members Health is concerned that the proposed changes alter the affordability equation late in life, at the very point when healthcare needs are most likely to increase.

This is not only a financial issue. Many older Australians view private health insurance as a form of security and self-reliance. For those members, the proposed change is experienced as a withdrawal of support after decades of participation in the system.

Members Health recognises that governments must adjust policy settings over time. However, such changes should be carefully designed, evidence-based and implemented in a manner that protects vulnerable cohorts and avoids unintended system consequences.

Members Health also notes that once an older Australian leaves private health insurance, returning later may be difficult and costly. Older Australians who lapse cover and later seek to re-enter the system may face higher costs under Lifetime Health Cover settings and may not have access to comparable products. For some older Australians, leaving private health insurance may be effectively irreversible.

We are particularly concerned for many of the older Australians on closed high cover policies that may not be able to downgrade to a level of cover that meets their needs. Many of these people will effectively be forced out of private cover and onto the public health system.

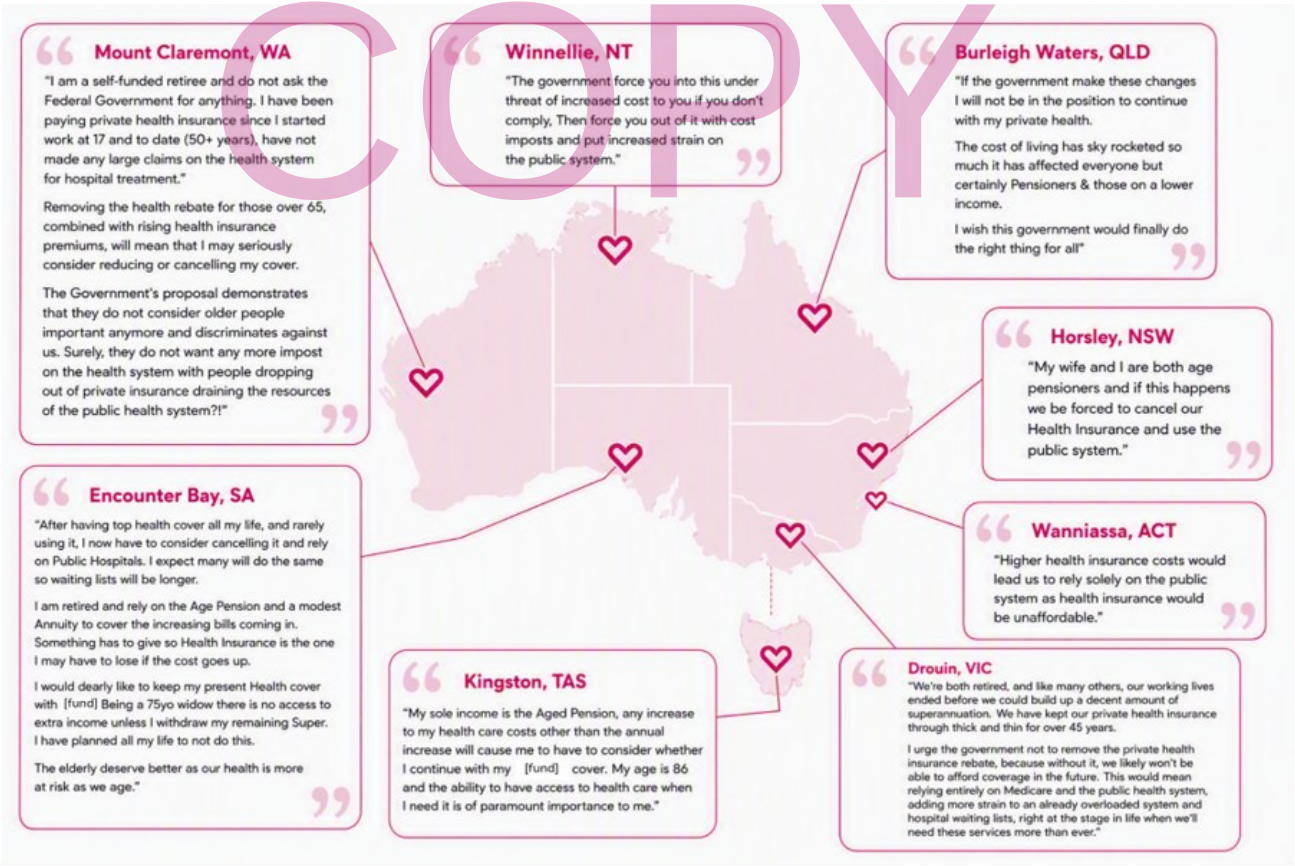
8. Consumer experiences and community feedback

Members Health's concerns are not theoretical. They are reflected in feedback from thousands of Australians and from member owned health funds that are very close to the communities they care for. Members Health has launched a national campaign inviting Australians to provide feedback on the proposed rebate changes. As of August 2026, more than 4,100 Australians had provided feedback through the campaign.

While specific questions were not asked and feedback was broad, analysis of responses identified several consistent themes:

- All respondents opposed changes to reduce the value of the rebate.
- 87 per cent of responses referenced financial strain or affordability concerns.
- 45 per cent indicated the person would either cancel, downgrade or seriously consider changing their private health insurance cover.

This feedback demonstrates that many older Australians are not viewing the proposal as a minor policy adjustment. Rather, they see it as a significant affordability pressure that may force them to reconsider private health insurance participation. **Many respondents explicitly indicated that if they can no longer afford private cover, they will rely on the public system and that they see this as Government betraying their long-term investment**. This is direct consumer evidence that demand will shift to public health, rather than disappear.



The themes in these responses are consistent. Older Australians are concerned about affordability, worried about losing access to timely care and conscious that any reduction in private cover will increase reliance on public hospitals.

Members Health submits that these responses should be considered as important evidence of likely behavioural responses.

9. People will not simply absorb the cost

A central assumption underpinning the Bill appears to be that most older Australians will absorb the increased cost and remain insured in broadly the same way. Members Health believes this assumption is unrealistic, particularly given current cost of living pressures.

The issue is not affordability alone. It is what consumers do in response to rising costs. Member funds have reported increased enquiries from older Australians concerned about affordability and whether they can retain cover. Consistent themes include long-term members reconsidering cover, fixed-income pressures and concern about moving into the public system.

Potential behavioural responses include:

- downgrading from Gold to lower-tier products;
- removing extras cover;
- increasing excesses or exclusions;
- delaying treatment;
- lapsing private health insurance entirely; and
- relying more heavily on public hospitals.

Members Health's national campaign feedback reinforces this concern. **In 45 per cent of survey responses, respondents indicated they would either cancel, downgrade or seriously consider changing their private health insurance cover.**

The Committee should not assess the proposal solely by reference to headline participation rates. Behavioural responses that fall short of cancellation may still have significant system consequences.

This is critical for public hospital planning. A person who downgrades or cancels private cover still requires healthcare. Their cataract surgery, joint replacement, cardiac care, oncology treatment, rehabilitation or mental health needs do not disappear. They are delayed, self-funded where possible, or shifted into the public system.

This policy was not foreshadowed with State Governments and given declines in the property market and State Government dependency on Stamp Duty, we question if state revenue will be sufficient to meet any increased demand on public hospital throughput.

10. Downgrading versus cancellation

Public discussion has largely focused on how many older Australians may leave private health insurance entirely.

Members Health submits that downgrading may be an equal or greater policy risk.
A person who remains insured but downgrades from comprehensive Gold cover to lower-tier hospital cover may still be counted as privately insured. However, that person may no longer be covered for key services they are likely to need.

This is particularly important for older Australians because many procedures commonly excluded or restricted in lower-tier products are services disproportionately used by older people. Downgrades from higher levels of cover typically mean removal of cover for services such as cataracts, joint replacements and mental health care.

Members Health is concerned that if downgrading is not properly modelled, the Government may underestimate public hospital impacts even if participation remains relatively high.

Lapse rates alone do not capture the full behavioural response to premium increases. A person may remain privately insured while downgrading to a product that no longer covers the services they are most likely to need. For this reason, downgrade behaviour should be considered separately when assessing public hospital and system-wide impacts.

Downgrading is therefore not merely a private health insurance issue. It is a public hospital access issue. If an older Australian remains insured but loses cover for the services they are most likely to need, those services may ultimately be sought through the public system.

11. Why downgrading matters

Remaining insured is not the same as remaining covered. This is a critical distinction. A member who downgrades may retain private health insurance but lose access to services due to downgrading cover, such as:

- cataract surgery;
- joint replacement;
- cardiac procedures;
- rehabilitation;
- mental health care; and
- other age-related services.

Mental health is a clear example of why downgrading should be modelled separately from lapsing. A person may remain privately insured but lose cover for psychiatric or mental health services under a lower-tier policy. Given existing pressure on public and community mental health services, any shift away from private coverage risks delaying care and increasing demand elsewhere in the system. If these services are no longer covered privately, affected members will seek treatment through the public system or delay treatment altogether.

Delayed treatment can lead to deterioration in health, greater complexity, reduced mobility, increased reliance on carers and, in some cases, earlier entry into aged care. Members Health is concerned that some older Australians may seek to manage the affordability shock by moving to much lower levels of cover that provide limited protection for the hospital services they are most likely to require. This may allow members to remain nominally insured while materially reducing the practical value of their cover.

Members Health submits that downgrade behaviour must be central to the Committee's assessment of the Bill.

The key question is not just: How many people remain insured? A key question is also: What services do people remain covered for?

This is especially important given the existing decline in comprehensive Gold cover.

Members Health has previously provided the Committee with evidence showing that Gold hospital cover has declined significantly since the introduction of standardised product tiers in 2019, while Gold premiums have increased substantially.

This reinforces the need to avoid policy changes that may accelerate downgrading from comprehensive cover.

Decline in Gold Hospital Treatment Policies[9]

Product Category	June 2020	December 2025	Change
Percentage of insurance population in Gold cover	**40.1%**	**29.3%**	**-10.8%** (absolute change)

If the proposed rebate change accelerates movement away from Gold products among older Australians, the consequences may result in the death knell for Gold Cover and reduced access to high-acuity private care, result in greater public hospital demand and place much further pressure on the sustainability of private hospitals.

12. Behavioural assumptions and modelling

The Minister's Second Reading Speech[10] indicated the Government's view that approximately 44,000 fewer people aged 65 and over are expected to be insured by 2028-29 than would otherwise have been the case, representing in the Minister's view, a relatively small change in participation.

Many Members Health funds have also modelled these changes and have determined that the government modelling appears grossly understated. Members Health has also seen exclusive research conducted by the Redbridge Group that indicates that 39 per cent of people over 65 would drop their cover should these changes proceed. This is consistent with Members Health's own survey findings mentioned earlier.

Even if the Government's estimate is accepted, 44,000 fewer older Australians with private cover is not immaterial. The Committee should carefully examine the assumptions behind this estimate, particularly given the absence or limited treatment of downgrade behaviour.

Members Health is also concerned that the government's modelling draws on price elasticity experience from periods of relatively modest premium changes and more favourable economic conditions. As a result, it may not fully reflect current cost-of-living pressures, inflationary conditions and consumer sensitivity to more substantial (e.g. greater than 15 per cent) premium increases.

Actuarial advice provided to Members Health has emphasised that uncertainty around behavioural responses remains material. In particular, results are sensitive to assumptions regarding both lapsing and downgrading. Downgrade behaviour is likely to be a key determinant of system impacts and should be modelled in addition to modelling lapse impacts.

Behavioural responses to premium increases are unlikely to be linear and are likely to differ with economic conditions and health status. Many retirees are on fixed incomes, health insurance competes against essential household spending, and affordability pressure accumulates and must be understood in the context of other cost of living pressures rather than simple price elasticity of demand modelling based on a limited set of inputs.

The key question is not whether behaviour changes. The key question is how much.

Members Health understands that a number of individual health insurers are likely to provide their own submissions detailing fund-specific modelling of expected behavioural

[9] Department of Health, Disability and Ageing's private health insurance reform data quarterly trend report, December 2025
[10] Minister Butler Second Reading Speech, *Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026*, 25 June 2026

responses. While Members Health does not seek to summarise or pre-empt those analyses, we note that feedback from across the not for profit and member owned health funds has consistently raised concern that behavioural responses, particularly downgrades, may be greater than assumed in the Government's modelling.

The Committee should be particularly cautious about relying on headline participation estimates if those estimates do not fully capture product downgrades, exclusions, changes in excesses, movement away from Gold cover or delayed treatment. Each of these behaviours may increase pressure elsewhere in the health system.

13. Demand Does Not Disappear: Public Hospital Access and Equity

Healthcare demand does not disappear because private health insurance becomes less affordable. Where older Australians downgrade or leave cover, treatment is delayed or shifted into the public system, increasing waiting lists and pressure on State and Territory health budgets.

These consequences are not limited to former private patients. Longer public hospital waiting lists affect all patients, particularly lower-income Australians, people with chronic illness, regional communities and those unable to self-fund timely care. Older Australians accounted for 48.8 per cent of private hospital admissions in 2023-24, so even a modest behavioural response among this cohort may have significant implications for public hospital capacity.

The Bill may therefore worsen health equity rather than improve it.

For this reason, the Bill should be considered as a whole-of-health-system measure. A policy that reduces Commonwealth rebate expenditure but increases demand on public hospitals risks worsening access and equity across the broader healthcare system.

This is particularly relevant to the Committee's consideration of equity. If a policy reduces support for lower-income older Australians and increases pressure on public hospitals used by lower-income Australians more broadly, it will worsen health inequity rather than improve it.

14. Fiscal consequences and cost shifting

Members Health is concerned that the proposal risks becoming a false economy.

Previous Government-funded actuarial modelling indicates that the proposed change may reduce Commonwealth rebate expenditure by around $482 million while shifting approximately $547 million in additional costs onto public hospitals. This is why the Bill should be assessed on a whole-of-health-system basis, rather than solely by reference to Commonwealth rebate expenditure.

The findings are also consistent with earlier government-commissioned analysis by NEAA Associates[11], which examined the public hospital costs avoided through private health insurance participation. That analysis found that the higher rebate for older Australians may produce net savings to government once avoided public hospital expenditure is taken into account. Members Health notes that the Government has not publicly reconciled that earlier analysis with the assumptions underpinning the current Bill.

[11] NEAA Associates, Offset of public hospital cost and Net cost to the government of subsidising Private Health Insurance in Australia, August 29, 2022

Although precise estimates are sensitive to behavioural assumptions, the direction of effect is consistent: rebate savings are likely to be at least partly offset by costs elsewhere in the health system. This cost shift is also uneven because public hospital costs are shared with State and Territory governments, while rebate savings accrue to the Commonwealth. Savings in one part of the Budget should not create larger costs, longer waiting times and poorer outcomes elsewhere.

Members Health submits that the Committee should consider the fiscal impact of the Bill across the whole health system, not only the Commonwealth rebate budget.

Members Health notes that concerns have also been raised by a number of State Governments publicly about the potential for this policy to shift additional demand onto already stretched public hospitals.

This is central to assessing whether the Bill represents sound public policy. A measure that reduces Commonwealth expenditure on the Private Health Insurance Rebate but increases public hospital costs, waiting times and delayed care may not produce a genuine system saving. It will move costs from one part of the healthcare system to another and achieve poorer health outcomes.

15. Private hospital viability

Private hospitals are an essential part of Australia's healthcare system. They undertake a substantial share of elective surgery and provide important capacity that would otherwise need to be absorbed by the public hospital system.

Older Australians account for a significant share of private hospital activity. **In 2023-24, 48.8 per cent of private hospital admissions were for people aged 65 and over**.

A behavioural response among older Australians therefore has implications beyond insurance participation. It affects almost half of private hospital activity.

The private hospital sector is already facing viability pressures. The Department's own assessment has recognised declining private hospital profitability and that several hospitals face near-term exit risk.

Members Health is concerned that reducing participation or coverage among older Australians will further weaken private hospital activity, particularly in regional areas and among standalone facilities.

If private hospitals become less viable, consequences may include:

- reduced local access to surgery;
- fewer available beds;
- reduced specialist activity;
- greater reliance on public hospitals;
- reduced competition and choice; and
- worse access for all patients, not only older Australians.

The proposal therefore has consequences for the entire health system, not only for private health insurers or older policyholders. Private hospital viability is also a public hospital issue. If private hospitals reduce services or close, the public system must absorb additional demand. This affects all patients, including those who have never held private health insurance.

16. Regional and rural Australia

Regional communities often have older populations, poorer health outcomes, fewer providers and greater reliance on local public and private hospitals. In these markets, even modest reductions in privately funded activity may affect service viability, specialist availability and public hospital waiting times.

The impact will be felt nationally, but Members Health analysis indicates that regional areas of Australia will have particularly high proportions of insured people affected.

Private hospitals in regional areas are often important anchor institutions. They support local surgical capacity, specialist availability and patient choice. If private hospital activity declines, specialist recruitment and retention can become more difficult.

Loss of private hospital viability ultimately means loss of doctors, services and access to care.

Members Health analysis indicates that Tasmania has one of the highest proportions of fund insured persons impacted, reinforcing the importance of considering regional and smaller-market effects.

	Persons impacted	65 - 69	70+	% of fund persons impacted
ACT	48,114	13,590	34,525	15.5%
NSW	899,305	252,253	647,052	18.8%
VIC	673,877	187,123	486,754	18.9%
QLD	539,931	151,807	388,124	19.4%
WA	327,685	97,438	230,248	16.4%
SA	246,354	64,410	181,945	23.6%
TAS	76,364	21,329	55,035	26.3%
NT	13,653	5,135	8,518	11.3%
Industry	**2,825,284**	**793,084**	**2,032,200**	**19.0%**

The impact of the Bill is likely to be greater in regional communities than headline national participation estimates suggest. A small reduction in private participation in a regional community may be enough to affect the viability of services, the availability of specialists and public hospital waiting times.

Members Health
FUND ALLIANCE

Case Study: Tasmania

Tasmania provides a practical example of the risks associated with the proposed rebate changes and why the health system consequences of this Bill matter. In a smaller state with an ageing population, higher chronic disease burden, limited specialist availability and long public hospital waiting lists, even a modest shift from private to public care can have significant consequences.

St Lukes, a Tasmanian not-for-profit Members Health fund and the largest provider of private health insurance in the state, has warned that the proposed rebate changes could have significant consequences for Tasmanian consumers and the broader state health system.

St Lukes has surveyed more than 3,700 of its members aged over 65 regarding the proposed changes. The survey found:

- 96 per cent are concerned about the proposed rebate changes;
- 71 per cent said the changes would affect their ability to keep private health insurance;
- 90 per cent lacked confidence in accessing the care they need through the public system;
- 77 per cent earned less than $55,000 annually; and
- 32 per cent earned less than $30,000 annually.

These findings reinforce Members Health's broader concern that the proposal will disproportionately affect lower-income older Australians and that behavioural responses may be significant.

St Lukes has highlighted that approximately 60 per cent of hospital admissions in Tasmania involve people aged 65 and over. It has also identified that in the federal electorates of Clark and Franklin, more than 137,000 people are covered by private health insurance, supporting more than 52,000 hospital admissions annually and $205 million in hospital benefits.

Many of the procedures commonly claimed by St Lukes members include hip and knee replacements, cardiac procedures, spinal surgery and ophthalmology services. These are predominantly services used by older Australians.

Tasmania's public hospital system is already under enormous pressure.

St Lukes has noted that more than 9,000 Tasmanians are waiting for elective surgery, with only 45 per cent treated within clinically recommended timeframes[12]. It has also highlighted that public patients can wait around 280 days for urgent cardiac care.

Additional Tasmanian public hospital waiting time data reinforces this concern. In the year to June 2026, Launceston General Hospital recorded a 136-day wait for cataract extraction, a 181-day wait for total hip replacements, and a 259-day wait for total knee replacements.

These waits are often under reported as there can be long waits to receive a medical appointment to enter the waiting list. These are exactly the types of procedures disproportionately required by older Australians and at risk of being shifted to the public system if people downgrade or cancel private cover.

Members Health is concerned that any shift of activity from private hospitals to public

[12] Tasmanian Department of Health's Health System Dashboard: Health System Dashboard - Daily | Tasmanian Department of Health

hospitals would further increase waiting times and reduce timely access to care.

Tasmania also demonstrates the link between private hospital viability and workforce sustainability.

Private hospitals help make specialist practice viable in regional and smaller markets. If private hospital activity declines, it may become harder to attract and retain specialists. This has consequences for both public and private patients.

For Tasmania, where access to specialists is already more constrained than in larger mainland cities, any reduction in private hospital activity could have system-wide consequences.

Tasmania therefore illustrates how even relatively small reductions in private participation among older Australians can have disproportionate impacts on public hospitals, private hospitals, workforce sustainability and access to care.

Importantly, these risks extend beyond Tasmania. Tasmania is frequently an early indicator of challenges facing regional Australia, providing valuable insight into the consequences that may emerge in other jurisdictions facing similar demographic and workforce pressures.

17. Aged care impacts and broader health sector concerns

The Government has stated that savings from the proposed rebate changes will support aged care. Members Health supports the objective of strengthening aged care but not at the expense of healthcare. We do not see the logic in removing aged care support for older Australians to theoretically support funding of aged care for older Australians.

Members Health is concerned that the proposal will inadvertently increase pressure on the aged care system it seeks to support by reducing access to healthcare for Australians over 65 years of age.

The joint sector letter[13] notes that approximately 78,000 permanent residential aged care residents currently hold private hospital cover, alongside a larger group of home care recipients.

Sector analysis estimates 2,800 to 3,500 aged care residents per year may face delayed access to elective surgery as a result of the policy.

Delayed cataract surgery, joint replacement and cardiac treatment can contribute to falls, reduced mobility, loss of independence and increased care needs.

Delayed access to procedures such as cataract surgery, joint replacement and cardiac care can have serious consequences for frail older people, including falls; fractures; reduced mobility; loss of independence; poorer quality of life; and increased care needs.

A policy intended to fund aged care should not inadvertently increase demand for it by reducing access to healthcare that helps older Australians remain independent.

Members Health is not alone in raising these concerns. A broad coalition representing insurers, hospitals, doctors, medical technology suppliers, consumers and older Australians

[13] Appendix B

has written to the Prime Minister and Health Minister[14] warning that in addition to aged care, the proposal may impact the health are care economy more broadly including adverse impacts on consumer affordability, public hospitals, private hospital viability, regional access.

The breadth of this coalition reflects the seriousness of the impacts and the Committee should give significant weight to the cross-sector concern.

18. Impact on Carers and Families

Delayed treatment does not affect only the individual patient. It also affects spouses, adult children, family members and carers.

If older Australians lose access to timely care, families may face increased caring responsibilities. This can affect workforce participation, financial security and mental health, particularly for the *"sandwich generation"* caring for both children and ageing parents.

Members Health is concerned that these broader social impacts have not been adequately considered in the policy design. The feedback received by Members Health is that younger Australians are very concerned at the policy proposal.

The Committee should consider whether the proposal may increase informal care pressures at the same time governments are seeking to improve aged care, disability support and hospital access.

This is another way in which the costs of the Bill may be shifted rather than reduced. Where care is delayed or access becomes more difficult, families and carers often absorb the burden. These costs may not appear in Commonwealth rebate modelling, but they are real negative costs to households and the broader economy.

19. Transparency and evidence gaps

Members Health is concerned that the Committee does not yet have sufficient visibility of the assumptions underpinning the Bill, particularly in relation to lapsing, downgrading, public hospital utilisation, private hospital viability, regional impacts, aged care consequences and impacts on low-income retirees and pensioners.

The legislation was introduced without adequate public or expert consultation, and the Government does not appear to have fully examined its effects on pensioners, lower-income retirees and other vulnerable cohorts.

The Government has also not published sufficient information about the characteristics of the older Australians its modelling assumes will leave private health insurance, including their incomes, pension status, location, current level of cover or expected healthcare utilisation.

Members Health submits that the Committee should not be asked to assess the Bill without full visibility of the key behavioural and system assumptions and without further community consultation.

Members Health also notes that the Department's own success metric appears to allow private health insurance participation to fall by up to one percentage point by the March

[14] See Appendix B.

2029 quarter compared with the March 2027 quarter. This raises important questions for the Committee. In particular, the Committee should consider how the Government will distinguish the impact of this policy from broader cost-of-living and affordability pressures, and what action would be taken if participation falls beyond the stated threshold.

Conclusion

Members Health supports the Government's objectives of strengthening aged care and ensuring public expenditure is used effectively.

However, the proposed removal of the higher Private Health Insurance Rebate for older Australians risks undermining affordability, weakening participation in private health insurance and creating negative unintended consequences across Australia's mixed public-private healthcare system.

The available evidence raises legitimate questions about whether the assumptions underpinning the Bill adequately account for:

- behavioural responses;
- downgrade behaviour;
- community rating;
- Gold cover sustainability;
- public hospital demand;
- private hospital viability;
- regional communities;
- aged care; and
- carers.

People will not simply be able to absorb the cost.

Demand for healthcare does not disappear because private health insurance becomes less affordable. It shifts.

The Bill is therefore not only a private health insurance issue. It is a whole-of-health-system issue. If older Australians downgrade or leave private cover, the impact will be felt across public hospitals, aged care, private hospitals, regional services and families.

Savings achieved in one part of the Budget should not create larger costs, longer waiting lists and poorer outcomes elsewhere in the healthcare system.

For these reasons, Members Health opposes the Bill and recommends that it not proceed.

We encourage the Committee to examine these matters and would welcome the opportunity to participate further in this process.

Yours sincerely

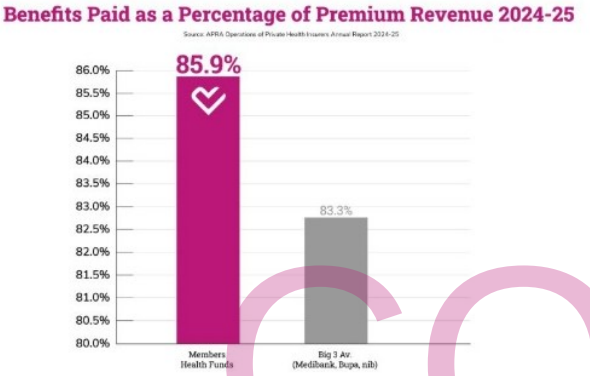
MATTHEW KOCE
Chief Executive Officer
Members Health Fund Alliance

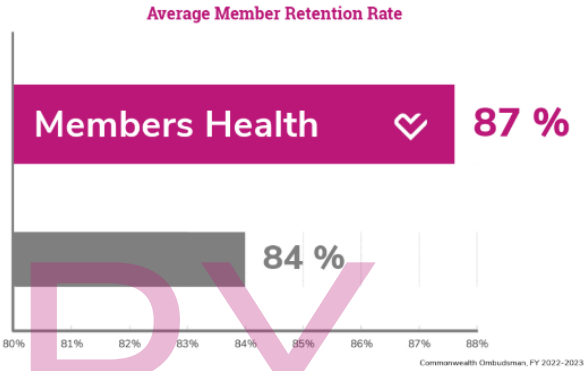
APPENDIX A

About Members Health – we're for people, not profit

Members Health is the national peak body for the not-for-profit, member-owned, regional, and community-based private health insurers. Collectively, around 80% of Australia's registered health funds are part of Members Health, covering a combined 5.4 million lives.

As mutual organisations, Members Health funds exist primarily to serve the interests of policyholders. Running prudently on narrow margins allows Members Health funds to return, on average, more of the premium dollar back to policyholders in healthcare benefits. Across Australia, Members Health funds are the success story of health insurance, offering highly competitive products, consistently achieving excellent customer service ratings and growing their membership year on year, with high policyholder retention rates.





Members Health funds are leaders when it comes to customer satisfaction. A 2026 independently run Ipsos survey recorded an average overall satisfaction rate of 89% among 25,168 Members Health fund respondents.

Ipsos advise that across both national and international benchmarks, there are very few organisations that could achieve such a high customer satisfaction score across so many respondents.

Members Health funds are close to their communities and have consistently experienced average policyholder growth that is competitive against the rest of the PHI industry. This growth is particularly evident in younger demographics, with the latest data showing a consistent rise in membership for those aged under 45 since 2018. Attracting younger and healthier policyholders is vital for maintaining a balanced risk pool, which helps place downward pressure on premiums for all members.

If it were not for Members Health funds, participation in private health insurance across Australia would likely be much lower than it is today. This highlights the ongoing importance of the not-for-profit, member-owned and community-based health sector to the sustainability of the private health system.

Our economic and social contribution to Australia

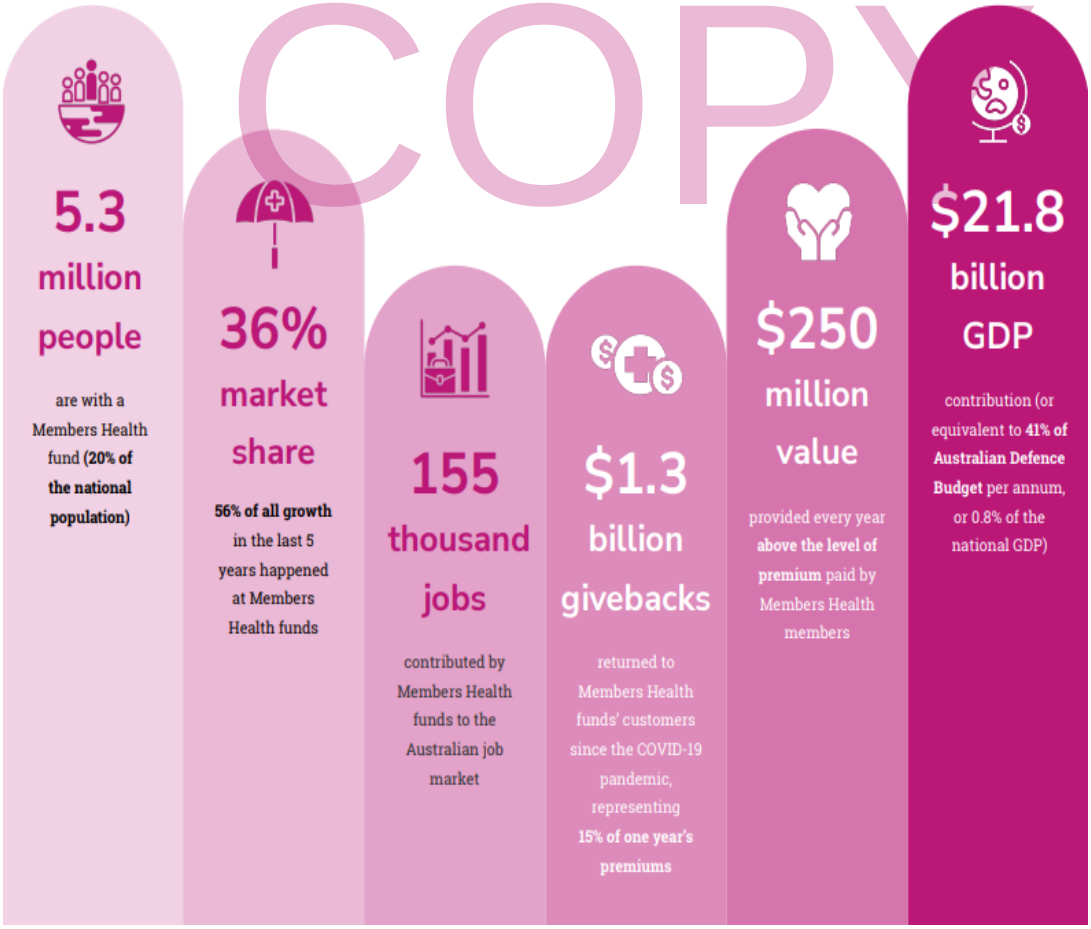
Members Health funds make a significant economic and social contribution to Australia.

Members Health funds are run by and for members who serve key industries, such as teachers, police, nurses and midwives, military, doctors and emergency services workers. There are Members Health funds headquartered in every state, in regional communities and the big cities. A number of Members Health funds are headquartered outside the major cities in locations such as Sunraysia, Illawarra, Latrobe Valley, Western NSW, Northern Queensland and Tasmania.

Many of the dental, optical and physio services available throughout rural and regional areas of Australia are dependent on the support of Members Health funds which help ensure that local people receive the care they need to sustain their health and wellbeing. In locations such as Sunraysia and Gippsland in Victoria, Members Health funds also provide access to vital healthcare services through the hospitals they own and run.

Members Health released its inaugural 'Economic and Social Impact of the Members Health funds of Australia', report in October 2024. The report highlights the important role that the not-for-profit, member-owned and community-based PHI funds play and continue to play in contributing to Australia's productivity and growth.

The report demonstrated that the Members Health insurers serve over 5.4 million Australian lives, including more than 1.1 million people living in regional and remote areas. Members Health funds contribute over $21.8 billion per annum to Australia's GDP.



Members Health funds provide over 155,000 direct and indirect jobs (including 28,000 direct and indirect jobs outside of the big cities). Members Health funds collectively ensure access to 6.4 million hospital bed days, 510,000 elective surgeries, and 37.8 million extras services each year.

APPENDIX B

11 June 2026

The Hon Anthony Albanese
MP Prime Minister of
Australia
Via email:
prime.minister@pm.gov.au Cc:
Minister.Butler@health.gov.au

Dear Prime Minister

Joint sector response: Removal of the age-based uplift to the Private Health Insurance Rebate

We write together as the peak bodies representing private health insurers, private and community hospitals, day hospitals, doctors, medical technology suppliers, and older Australians, to register our shared concern about the removal of the age-based uplift to the Private Health Insurance Rebate announced in the 2026- 27 Budget.

We support the Government's investment in aged care. We agree that the rebate system should be considered as part of broader reforms to the private health system, including reforms that address health inflation. But the measure as currently designed will fall hardest on the older Australians least able to absorb it, will shift substantial cost to public hospitals already operating at capacity, and will compound an emerging viability crisis in private hospitals, particularly in regional Australia. We believe it warrants further consultation before it proceeds to legislation.

The Australians who will be hit hardest

The measure directly affects more than 3 million older Australians, including many older people on modest incomes. The premium impact, while presented as modest in average terms, is significant for this cohort.

The academic literature the Department itself cites (Liu and Zhang, 2023) finds that low-income older Australians are several times more price-responsive than the cohort average. The policy treats all over-65s identically. The cohort the Government is least intending to displace (pensioners and low-income retirees) is the cohort most likely to drop or downgrade their cover.

The shift to public hospitals is real and unfunded

The Government has acknowledged in the Impact Analysis that public hospital cost shift "cannot be reliably quantified." Independent actuarial analysis by Finity found the cost shift to public hospitals would substantially offset the rebate saving. Sector analysis using more conservative assumptions reaches similar conclusions: most or all of the headline saving is returned to government as cost shift.

The cost shift falls disproportionately on state governments, who carry approximately 55% of the additional public hospital activity under the National Health Reform Agreement while receiving none of the rebate saving.

The Department's Impact Analysis acknowledges that downgrade behaviour, specifically patients moving from Gold to Silver or adding exclusions, was not included in the modelling, and that this could materially worsen the impact on public hospitals. Downgrades typically remove cover for cataracts, joint replacement and mental health, which are the services most needed by the 65+ years cohort.

The change will also impact the Government's efforts to improve access to the public hospital system. While additional Commonwealth funding under the National Health Reform Agreement is welcome, this policy change will undermine the Government's objectives. The Finity report shows that this measure will mean that more older people will end up in public hospitals and this will simply increase pressure on an already stretched system.

Private hospital viability is at a critical point

The Department's own Impact Analysis acknowledges that "the average profitability of the private hospital sector has declined" and that "several hospitals are at high risk of near-term exit." The Department's 2024 Private Hospital Financial Viability Health Check found parts of the sector are not generating the returns needed for continued investment.

Against this backdrop, the rebate change introduces additional revenue pressure into a sector already absorbing significant cost increases including nursing award outcomes of up to 35%. The impact will not be evenly distributed. Standalone facilities, particularly those in regional and rural Australia, will bear it most acutely. These are the hospitals with the highest concentration of older patients, the thinnest margins, and the fewest options for absorbing volume loss. Several are the only private alternative in their catchment.

In 2023-24, 48.8% of all private hospital admissions in Australia were of people aged 65 and over. A behavioural response that materially affects this cohort affects almost half of private hospital activity. For regional facilities serving older catchments, the share is substantially higher.

Aged care residents will be directly affected

Approximately 78,000 permanent residential aged care residents currently hold private hospital cover, alongside a larger group of home care recipients. Sector analysis estimates 2,800 to 3,500 aged care residents per year will face delayed access to elective surgery as a result of this policy. The clinical literature on delayed cataract surgery, joint replacement, and cardiac procedures in this frail cohort is unambiguous: outcomes are materially worse, with documented increases in falls, fractures, loss of mobility and mortality.

This creates a self-defeating dynamic in the policy. Delayed elective surgery for home care recipients accelerates transitions into residential aged care — increasing demand on the same Aged Care Package the rebate saving is intended to fund.

What we are asking

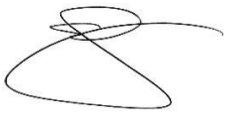
We are asking the Government to consider the following:

1. **The effect on low-income older Australians:** Many older Australians live on lower and fixed incomes and are more likely to struggle with significant price increases.
2. **The impact on public hospitals:** The measure will see more older patients in public hospitals, increasing waiting times for essential care, and undermine the Government's efforts to improve access to our public hospital system.
3. **The impact on regional and rural access:** The measure is likely to have a greater impact on regional and rural communities, where private hospital cover is often the only practical pathway to timely care and where private hospital viability is most fragile.
4. **Publish the modelling to inform the debate:** On private health insurance product downgrades, the cost shift to public hospitals, the impact on private hospital viability, the impact on aged care residents, and the effect on regional facilities should all be quantified and published before legislation.

A constructive path forward

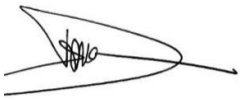
The sector is willing to work with the Government on the issues raised in this letter as well as broader private health reforms. Each of the signatories below has expertise and data that can support a more durable policy outcome. We would welcome the opportunity to meet with you and your office to discuss the issues raised in this letter and to assist in developing a workable solution that protects vulnerable Australians, protects regional access, and preserves the substantial majority of the fiscal saving.

Yours sincerely,



Chris Grice
CEO National Seniors Australia

Lisa Robins
CEO Patients Australia



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